

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13743

CERTIFICATE OF DEATH

Reg. Dist. No.

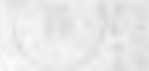
13717

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Preston ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Horse Shoe Run, W.Va. 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Rest Home		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julius Middle Elmer Last Arnold		4. DATE OF DEATH Month Dec. Day 7, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY W.Va.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Arnold		14. MOTHER'S MAIDEN NAME Elizebeth Fike	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-1679A	
17. INFORMANT Glenn Arnold		Address Charleston, W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 493X DUE TO (c) 2 days		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease - Advanced		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 19 57 to December 7, 19 59 , that I last saw the deceased alive on December 6, 19 59 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED 7 Dec 59	
PHYSICIAN'S NAME (Type) Herbert H. Leighton		77 Oak Street Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/9/59	22c. NAME OF CEMETERY OR CREMATORY Eglon	22d. LOCATION (City, town, or county) (State) Eglon, W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Higgin		ADDRESS Davis, W.Va.	
24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

CERTIFICATE OF DEATH

1934

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Jan 15 1934</i>
AGE <i>45</i>		SEX <i>Male</i>
RACE <i>White</i>		EDUCATION <i>High School</i>
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, Md</i>
CAUSE OF DEATH <i>Heart Disease</i>		PLACE OF DEATH <i>Home</i>
MANNER OF DEATH <i>Natural</i>		REPORTED BY <i>Dr. Smith</i>
SIGNATURE OF DECEASED		SIGNATURE OF REPORTER
DATE OF SIGNATURE		DATE OF SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13718

13744

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Tucker</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>21 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett Co. Memorial Hospital</u>				d. STREET ADDRESS <u>85 X - 3</u>			
3. NAME OF DECEASED (Type or print) First <u>Marquis</u> Middle <u>B</u> Last <u>Cross</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>59</u> Min <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Parsons, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wateman Cross</u>				14. MOTHER'S MAIDEN NAME <u>Chollita Wratford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>War 11</u>		16. SOCIAL SECURITY NO. <u>232-10-8324</u>		17. INFORMANT <u>"Wife" Molly G. Cross</u>		Address <u>Davis, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Lung, Primary.</u> DUE TO (c) <u>Metastasis to Liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>6 mos</u> <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 12</u> , 19 <u>57</u> , to <u>12-3-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-3-59</u> , 19 <u>59</u> , and that death occurred at <u>8:10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>				ADDRESS (Street, city or town, state) <u>58 2nd St. Oaklands - d</u>		DATE SIGNED <u>12-3-59</u>	
PHYSICIAN'S NAME (Type) <u>James H. Feaster Jr., M. D.,</u>				<u>Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis</u>		22d. LOCATION (City, town, or county) (State) <u>Davis, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Spiggle</u>				ADDRESS <u>Davis, W. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

Form with multiple horizontal lines for text entry, including fields for name, age, sex, date of death, and cause of death.

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13745

CERTIFICATE OF DEATH

Reg. Dist. No.

13719

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle Lena Last DeVelbiss				4. DATE OF DEATH Month December Day 9 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/1886 1894	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Martin, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Rotruck			14. MOTHER'S MAIDEN NAME Malinda Cooper				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Curtis V. DeVelbiss (Son)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, bilateral, terminal 420.1 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7-59 , 19 to 12-9-59 , 19, that I last saw the deceased alive on 12-9-59 , 19, and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2nd. St., Oakland, Md. DATE SIGNED 12-9-59 ACTUAL SIGNATURE James H. Feaster, Jr. M.D. PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11 Dec 59	22c. NAME OF CEMETERY OR CREMATORY Knobley Cemetery		22d. LOCATION (City, town, or county) (State) Martin, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Allen Rotruck				ADDRESS Keyser, W. Va.		24a. REC'D BY REGISTRAR DATE DEC 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD CERTIFICATE OF DEATH

1942

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Date of filing: _____

14. File number: _____

15. Registrar's office: _____

16. County: _____

17. State: _____

18. City: _____

19. Zip: _____

20. Telephone: _____

21. Address: _____

22. Name: _____

23. Title: _____

24. Signature: _____

25. Date: _____

26. File number: _____

27. Registrar's office: _____

28. County: _____

29. State: _____

30. City: _____

31. Zip: _____

32. Telephone: _____

33. Address: _____

34. Name: _____

35. Title: _____

36. Signature: _____

37. Date: _____

38. File number: _____

39. Registrar's office: _____

40. County: _____

41. State: _____

42. City: _____

43. Zip: _____

44. Telephone: _____

45. Address: _____

46. Name: _____

47. Title: _____

48. Signature: _____

49. Date: _____

50. File number: _____

51. Registrar's office: _____

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55. Zip: _____

56. Telephone: _____

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58. Name: _____

59. Title: _____

60. Signature: _____

61. Date: _____

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108. Signature: _____

109. Date: _____

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111. Registrar's office: _____

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118. Name: _____

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120. Signature: _____

121. Date: _____

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123. Registrar's office: _____

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130. Name: _____

131. Title: _____

132. Signature: _____

133. Date: _____

134. File number: _____

135. Registrar's office: _____

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143. Title: _____

144. Signature: _____

145. Date: _____

146. File number: _____

147. Registrar's office: _____

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152. Telephone: _____

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154. Name: _____

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156. Signature: _____

157. Date: _____

158. File number: _____

159. Registrar's office: _____

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166. Name: _____

167. Title: _____

168. Signature: _____

169. Date: _____

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175. Zip: _____

176. Telephone: _____

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178. Name: _____

179. Title: _____

180. Signature: _____

181. Date: _____

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184. County: _____

185. State: _____

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187. Zip: _____

188. Telephone: _____

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190. Name: _____

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192. Signature: _____

193. Date: _____

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196. County: _____

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202. Name: _____

203. Title: _____

204. Signature: _____

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209. State: _____

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211. Zip: _____

212. Telephone: _____

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216. Signature: _____

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220. County: _____

221. State: _____

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223. Zip: _____

224. Telephone: _____

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226. Name: _____

227. Title: _____

228. Signature: _____

229. Date: _____

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233. State: _____

234. City: _____

235. Zip: _____

236. Telephone: _____

237. Address: _____

238. Name: _____

239. Title: _____

240. Signature: _____

241. Date: _____

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244. County: _____

245. State: _____

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252. Signature: _____

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259. Zip: _____

260. Telephone: _____

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264. Signature: _____

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268. County: _____

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272. Telephone: _____

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274. Name: _____

275. Title: _____

276. Signature: _____

277. Date: _____

278. File number: _____

279. Registrar's office: _____

280. County: _____

281. State: _____

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283. Zip: _____

284. Telephone: _____

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293. State: _____

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304. County: _____

305. State: _____

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310. Name: _____

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312. Signature: _____

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315. Registrar's office: _____

316. County: _____

317. State: _____

318. City: _____

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320. Telephone: _____

321. Address: _____

322. Name: _____

323. Title: _____

324. Signature: _____

325. Date: _____

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328. County: _____

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432. Signature: _____

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467. Title: _____

468. Signature: _____

469. Date: _____

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472. County: _____

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474. City: _____

475. Zip: _____

476. Telephone: _____

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480. Signature: _____

481. Date: _____

482. File number: _____

483. Registrar's office: _____

484. County: _____

485. State: _____

486. City: _____

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488. Telephone: _____

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492. Signature: _____

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495. Registrar's office: _____

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531. Registrar's office: _____

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540. Signature: _____

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543. Registrar's office: _____

544. County: _____

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920. Telephone: _____

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923. Title: _____

924. Signature: _____

925. Date: _____

926. File number: _____

927. Registrar's office: _____

928. County: _____

929. State: _____

930. City: _____

931. Zip: _____

93

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13746
CERTIFICATE OF DEATH

13720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 26 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN HARRISON DE WITT				4. DATE OF DEATH Month Day Year DECEMBER 25 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1889		9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE DE WITT				14. MOTHER'S MAIDEN NAME MARY SANDERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address NELLIE C. DE WITT, REESE AND OAK ST., OAKLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma toxic 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the Lung DUE TO (c) (Bronchiogenic)						INTERVAL BETWEEN ONSET AND DEATH 3 months Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1958</u> to <u>Dec 25, 1959</u> , that I last saw the deceased alive on <u>Dec 24, 1959</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.		DATE SIGNED 25 Dec 59	
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.				OAKLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/1959		22c. NAME OF CEMETERY OR CREMATORY Red House Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Her Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1914

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

Form with multiple lines for recording death details, including fields for name, date, time, place, and cause of death. The form is oriented vertically on the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13721

13747

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN b 7 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRELLIN d. STREET ADDRESS BOX 141		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROY Middle CLIFFORD Last DUMIRE		4. DATE OF DEATH Month DECEMBER Day 2 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1911	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY COAL		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME GEORGE DUMIRE		14. MOTHER'S MAIDEN NAME FANNIE MOTRING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 233-09-2161		17. INFORMANT MRS. GERTRUDE DUMIRE, BOX #141, CRELLIN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, Basal Artery of Brain 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 8 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1 , 19 51 , to 11-30 , 19 59 , that I last saw the deceased alive on 11-30 , 19 59 , and that death occurred at 1:20 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md		DATE SIGNED 2 Dec 59	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		OAKLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/59		22c. NAME OF CEMETERY OR CREMATORY Shaffertown	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		ADDRESS Davis, W.Va.		24a. REC'D BY REGISTRAR DATE DEC 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kiana	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13748
CERTIFICATE OF DEATH

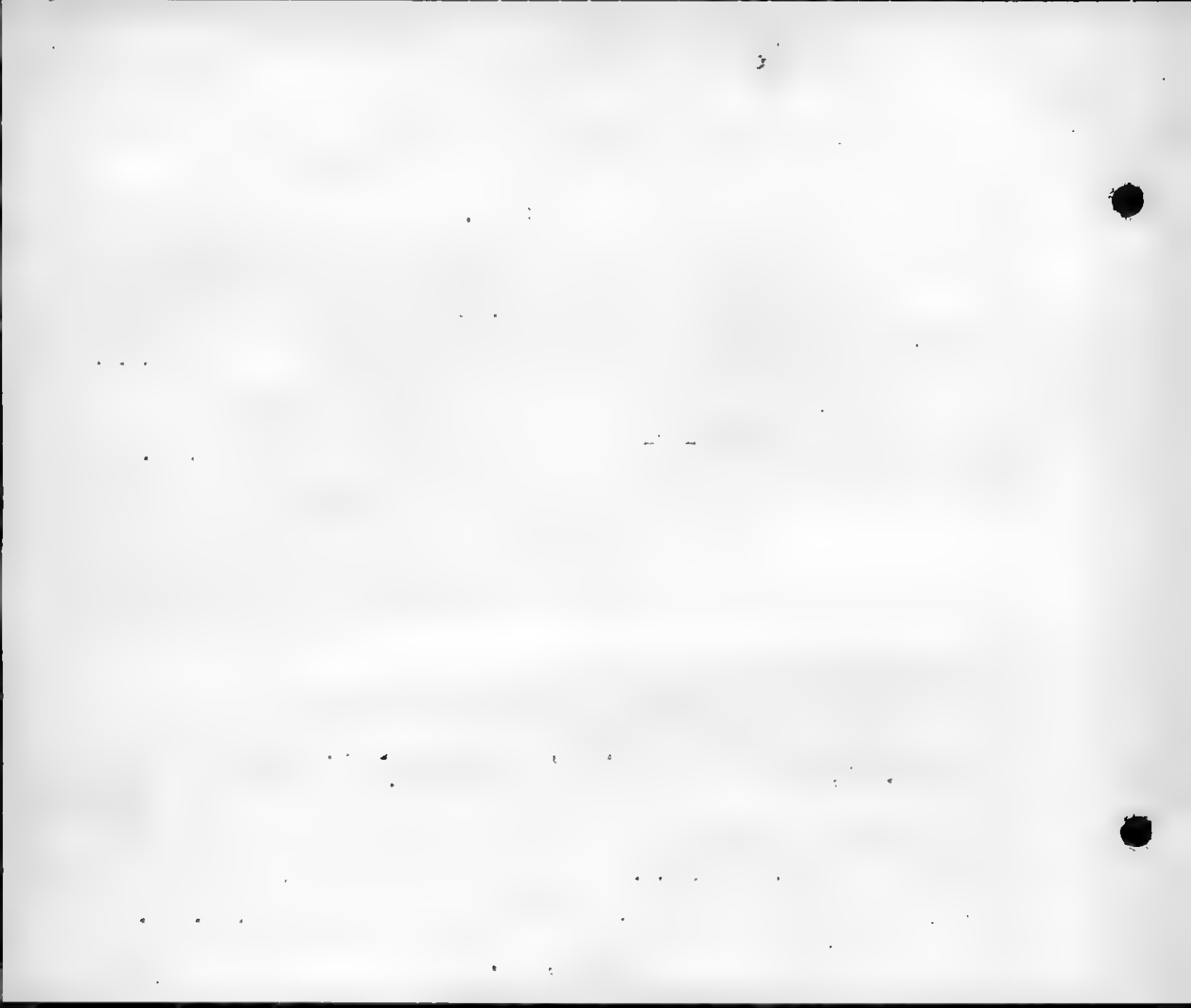
13722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM NOLAN EVANS		4. DATE OF DEATH Month Day Year DECEMBER 25 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 15, 1896
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID EDWARD EVANS		14. MOTHER'S MAIDEN NAME AMELIA FLORENCE SCHELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-07-1983	
17. INFORMANT ESTHER EVANS		Address KITZMILLER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 11, 1955 to Dec. 25, 1959 , that I last saw the deceased alive on Dec. 25, 1959 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED Dec 25	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/1959	22c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery	22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE A.C. Keightley		ADDRESS Oakland, Md.	24a. RECEIVED BY REGISTRAR DEC 28 59 DATE
		24b. REGISTRAR'S SIGNATURE Carlton S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

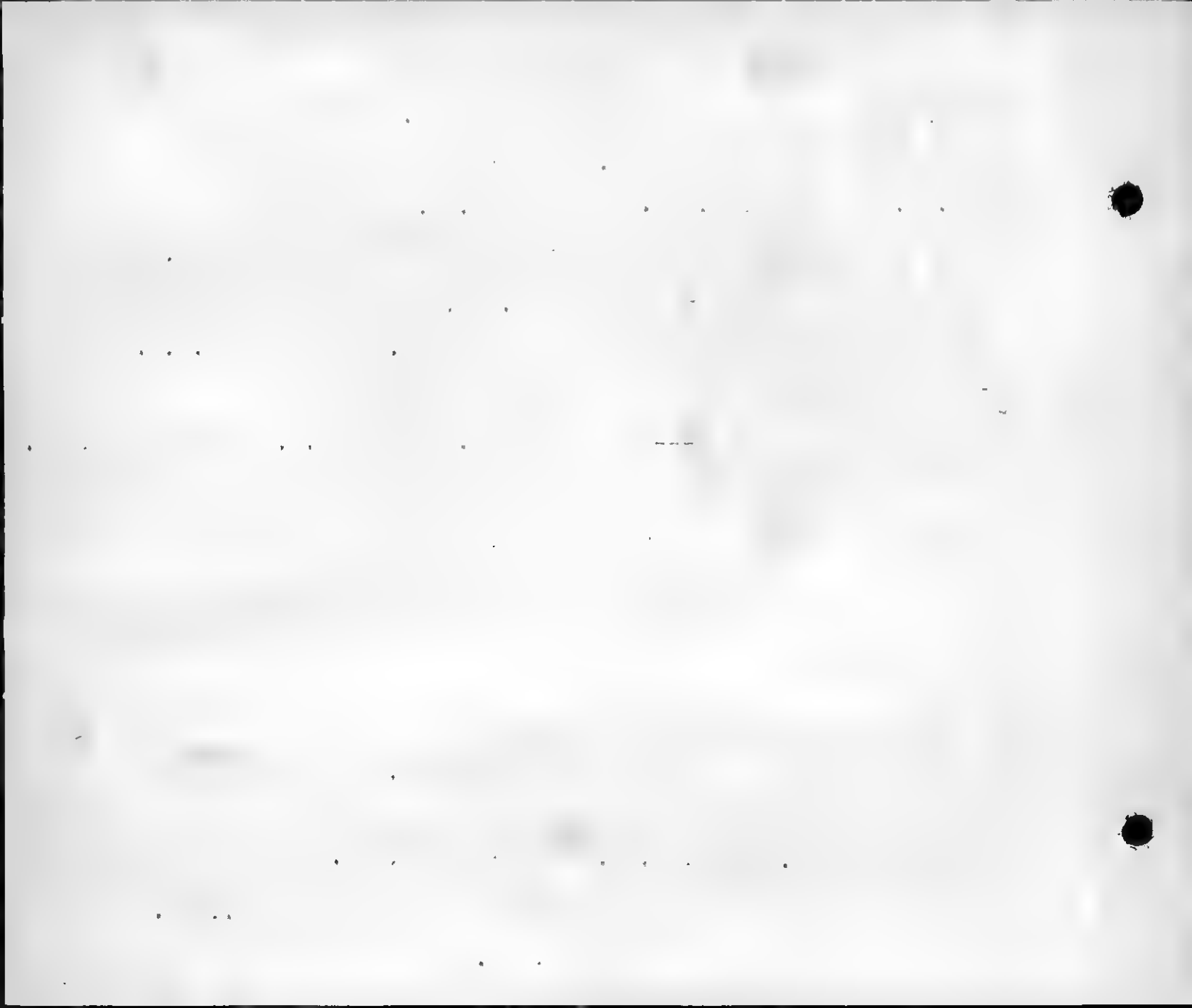
13749

CERTIFICATE OF DEATH

Reg. Dist. No.

13723

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Friendsville		c. LENGTH OF STAY IN 1b 65 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5 Mi. S. Friendsville, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle Fazenbaker Last Friend		4. DATE OF DEATH Month December Day 20, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1863
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months 6 Days 10 Hours 9 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Fazenbaker		14. MOTHER'S MAIDEN NAME Margaret Ormand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hubert A. Friend		Address R.D. Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial heart disease 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mos 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, Day, Year 12-20-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5:30P.
20f. (City or town) Oakland		(County) (State)	
21. I certify that I attended the deceased from 7-15-57 to 12-20-59 , that I last saw the deceased alive on 12-20-59 , and that death occurred at 5:30P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		DATE SIGNED 21 Dec 59	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/1959	22c. NAME OF CEMETERY OR CREMATORY Hoyes Cemetery	22d. LOCATION (City, town, or county) (State) Garrett Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. G. Lighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



13750

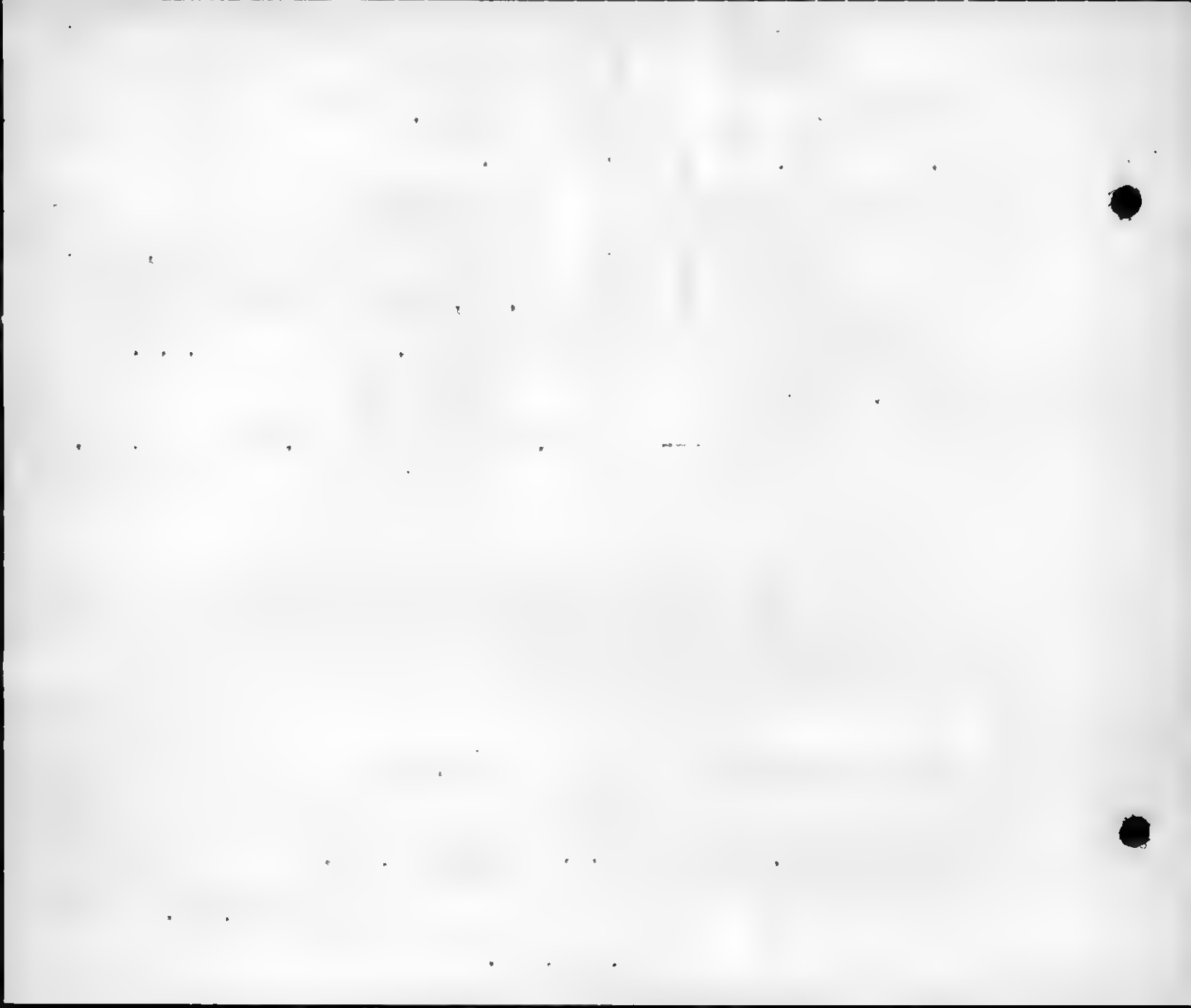
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "E" Street		e. STREET ADDRESS "E" Street	
3. NAME OF DECEASED (Type or print) Robert Lee Gauer		4. DATE OF DEATH Month December , Day 9 , Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1866
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob P. Gauer		14. MOTHER'S MAIDEN NAME Martha Wilt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Robert Gauer		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Malnutrition - Dehydration 4 in DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Vascular Disease DUE TO (c) Unknown			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July 1958</u> to <u>December 9, 1959</u> , that I last saw the deceased alive on <u>December 3, 1959</u> , and that death occurred at <u>9:30A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D.		ADDRESS (Street, city or town, state) <u>77 Oak St., Oakland, Md.</u> DATE SIGNED <u>11 Dec 59</u>	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/1959	22c. NAME OF CEMETERY OR CREMATORY Red House Cemetery	22d. LOCATION (City, town, or county) (State) near Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u>		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE DEC 15 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13751

CERTIFICATE OF DEATH

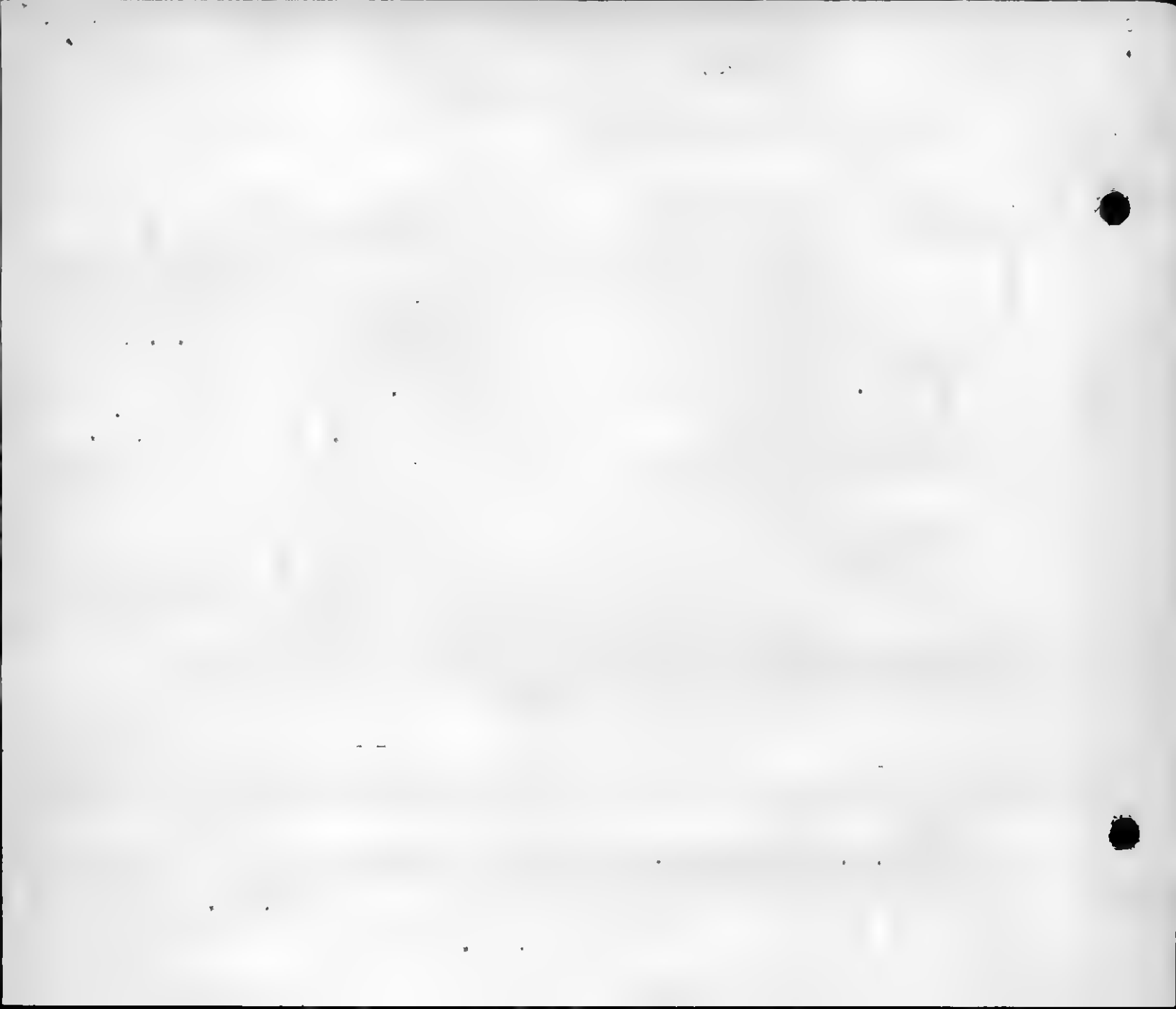
Reg. Dist. No.

13725

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS Mason Street			
3. NAME OF DECEASED (Type or print) First Evelyn Middle Victoria Last Green				4. DATE OF DEATH Month December Day 4 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 5, 1922	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 37 Days 37 Hours 37 Min.		IF UNDER 24 HRS. Months 37 Days 37 Hours 37 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Leon C. Shaffer				14. MOTHER'S MAIDEN NAME Eleanor V. Hardesty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT "Husband" Warren L. Green		Address Mason St. Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 593X DUE TO Stomach rupture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stomach rupture (c) Stomach rupture							INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 11 Day 26 Year 1959 Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Oakland				20g. (County) Garrett		20h. (State) Md.	
21. I certify that I attended the deceased from 11/26/59 , 19 59 , to 12-4-59 , 19 59 , that I last saw the deceased alive on 12-4-59 , 19 59 , and that death occurred at 6:50 A M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 25 Archer St. Oakland, Md.				DATE SIGNED 12/4/59			
ACTUAL SIGNATURE E. I. Baumgartner				DATE SIGNED 12/4/59			
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.				ADDRESS Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/1959		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. E. Reighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13752

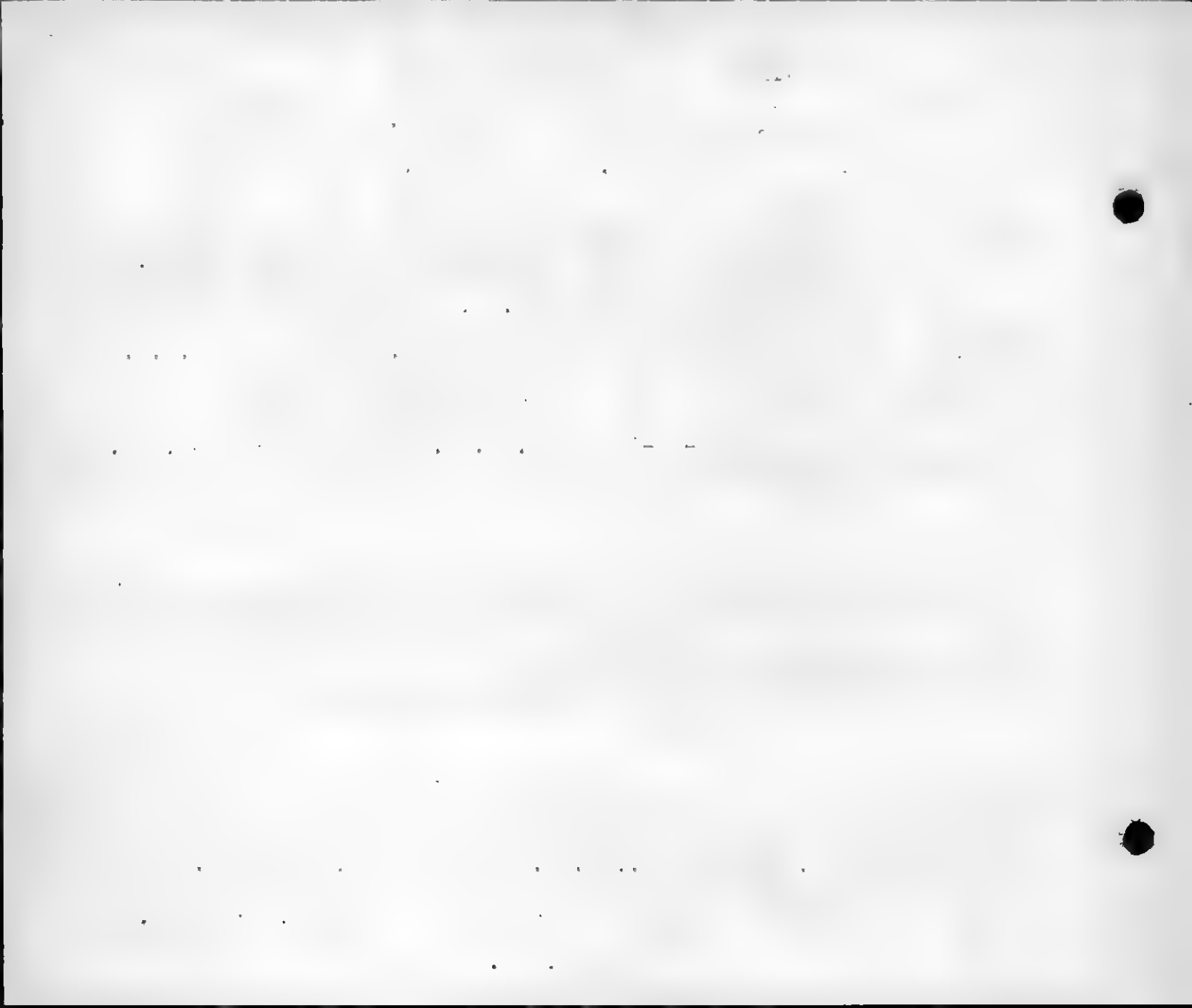
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,			
c. LENGTH OF STAY IN 1b 60 yrs.				d. STREET ADDRESS Second Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Second Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Friend Last Hammond				4. DATE OF DEATH Month December Day 31, Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1865	
9. AGE (In years last birthday) 94 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant & Builder		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gabriel Hammond				14. MOTHER'S MAIDEN NAME Mary Elizabeth Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-3475		17. INFORMANT Mrs. C. F. Hammond Address Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis GENERALIZED YEARS DUE TO (c) Sclerosis Coronary & Intestine YEARS							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 19 Dec 20 , 19 59 , that I last saw the deceased alive on Dec 20 , 19 59 , and that death occurred at 1:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) OAKLAND, MD DATE SIGNED 1-1-60							
ACTUAL SIGNATURE James H. Feaster Jr. M.D.				PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D. Oakland, Maryland.			
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 1/3/1960		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE JAN 5 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13753

CERTIFICATE OF DEATH

Reg. Dist. No.

13727

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE MD	c. LENGTH OF STAY IN 1b LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SAMUEL Middle E. Last HERSHBERGER			4. DATE OF DEATH Month 12 Day 9 Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 5 1875	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (State or foreign country) GARRETT Co MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME EMANUEL HERSHBERGER		
14. MOTHER'S MAIDEN NAME MARY MILLER			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Eli Zaden, Grantsville, Md		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 5 years
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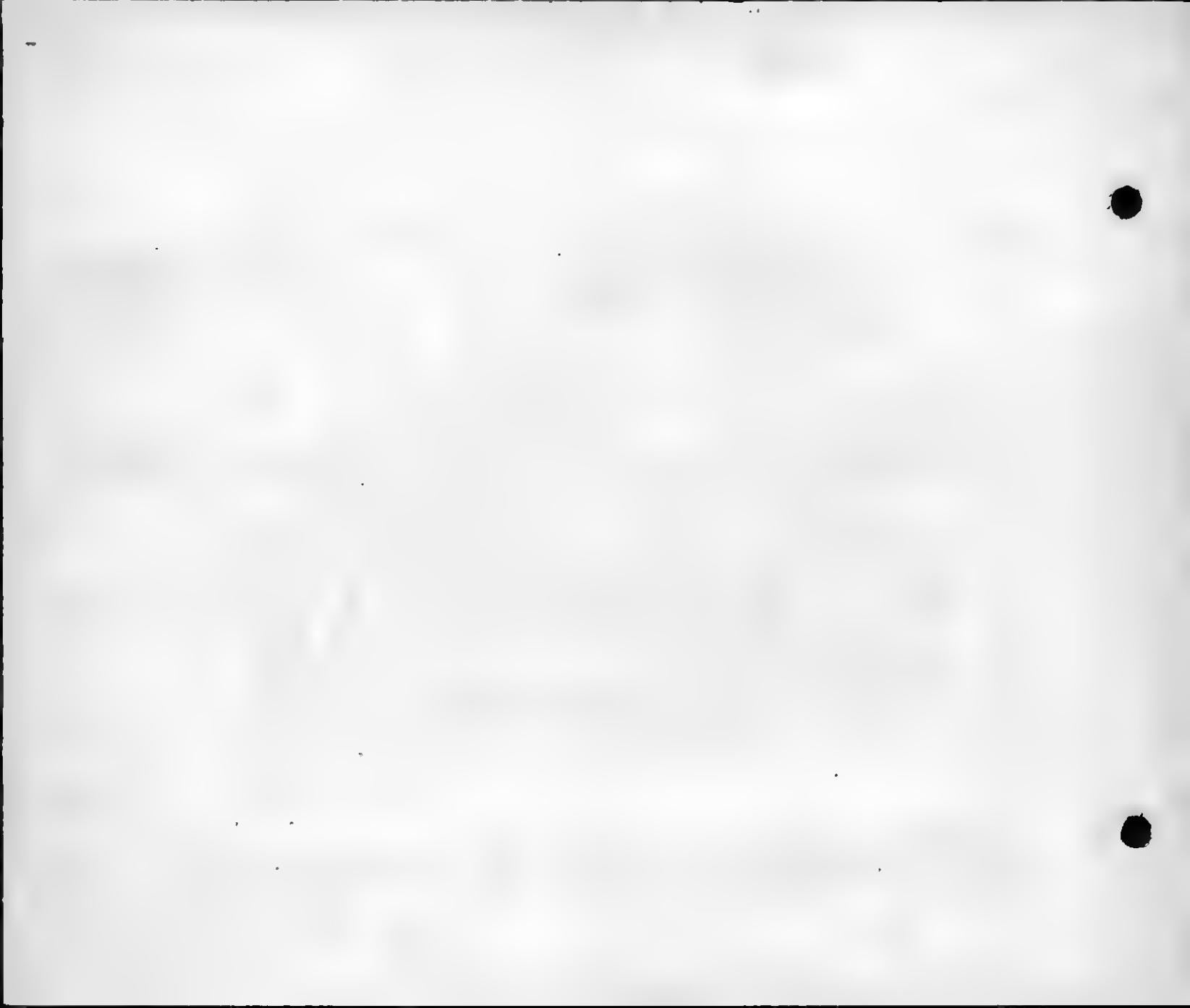
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 2 , 19 59 , to Dec. 9 , 19 59 , that I last saw the deceased alive on Dec. 8 , 19 59 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE A. Paige Strong M.D.	ADDRESS (Street, city or town, state) Grantsville, Md.
PHYSICIAN'S NAME (Type) A. Paige Strong	DATE SIGNED 12/11/59

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/11/59	22c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW	22d. LOCATION (City, town, or county) (State) WEST SALISBURY, SOMERSET Co, PA
23. FUNERAL DIRECTOR'S SIGNATURE Ron Newman, Grantsville, Md		24a. REC'D BY REGISTRAR DATE DEC 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13754

CERTIFICATE OF DEATH

Reg. Dist. No.

13728

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY CECIL HOOVER</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Jennings, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Hoover</u>		14. MOTHER'S MAIDEN NAME <u>Clive Hoover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>200-07-0431</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial failure</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic rheumatic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 20, 1958</u> , to <u>Dec. 20, 1959</u> , that I last saw the deceased alive on <u>Dec. 19, 1959</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D.		ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u> DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>A. Paige Strong, M.D.</u>		<u>Grantsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Dec. 22, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Grantsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. ...</u> ADDRESS <u>...</u>		24a. REC'D BY REGISTRAR <u>...</u> DATE <u>DEC 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. ...</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



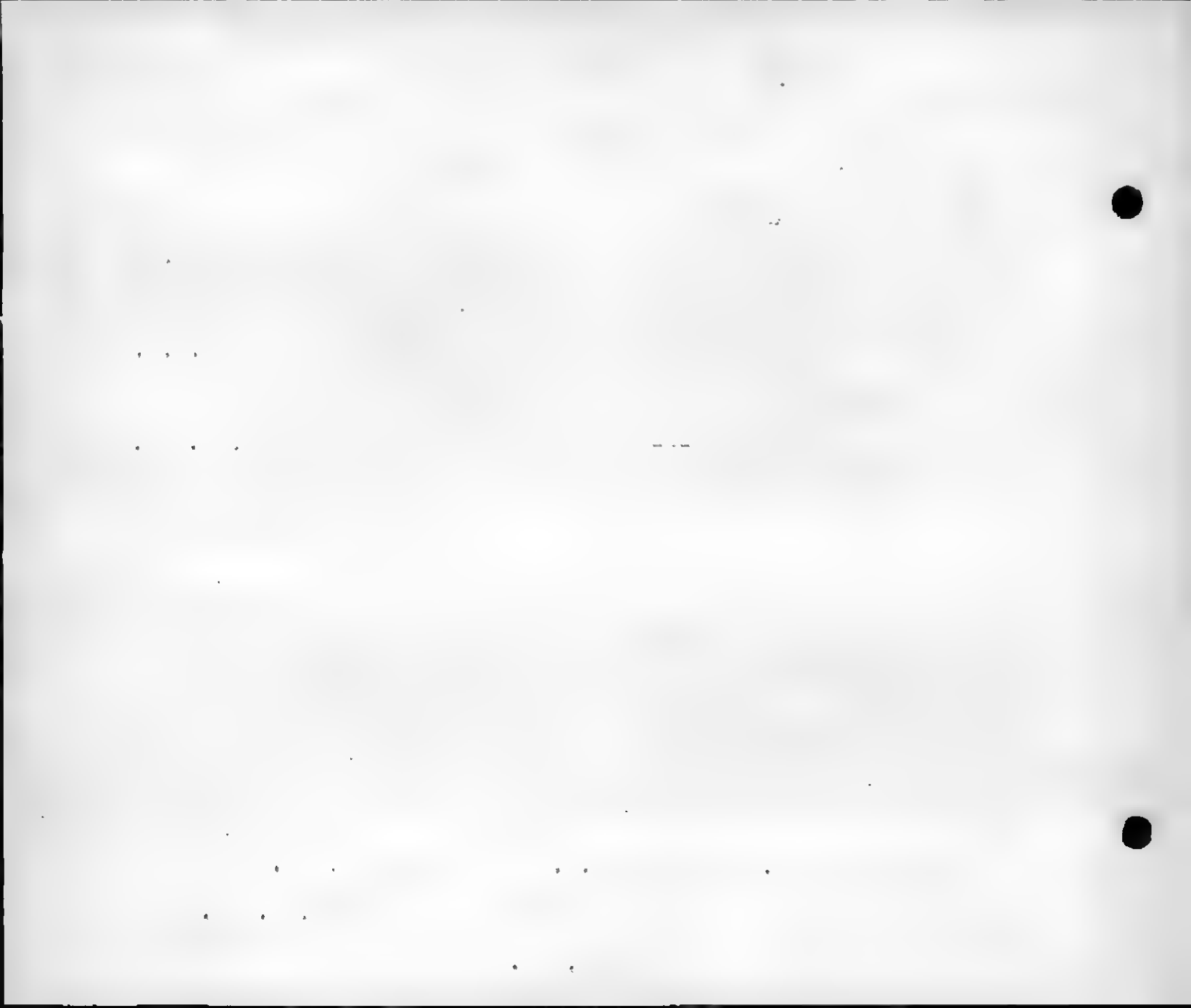
CERTIFICATE OF DEATH

Reg. Dist. No.

13755

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. COUNTY Grant West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS 85 X 2	
3. NAME OF DECEASED (Type or print) First Emma Middle Jane Last Kitzmiller		4. DATE OF DEATH Month December Day 13, Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ervin Boring		14. MOTHER'S MAIDEN NAME Rebecca Grant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT George Boring		Address Bayard, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 41.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of the Coronary Arteries Unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip - Open Reduction - healed			INTERVAL BETWEEN ONSET AND DEATH 5 minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell while starting to sit in Chair			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. Nov 6 1959 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Bayard Grant West Virginia
21. I certify that I attended the deceased from Nov 6, 1959 to December 13, 1959 , that I last saw the deceased alive on December 10, 1959 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 27 Oak St. Oakland, Md. 14 Dec 59	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/16/1959	22c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery	22d. LOCATION (City, town, or county) (State) Bayard, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE DEC 18 '59
		24b. REGISTRAR'S SIGNATURE Charles E. ...	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13758

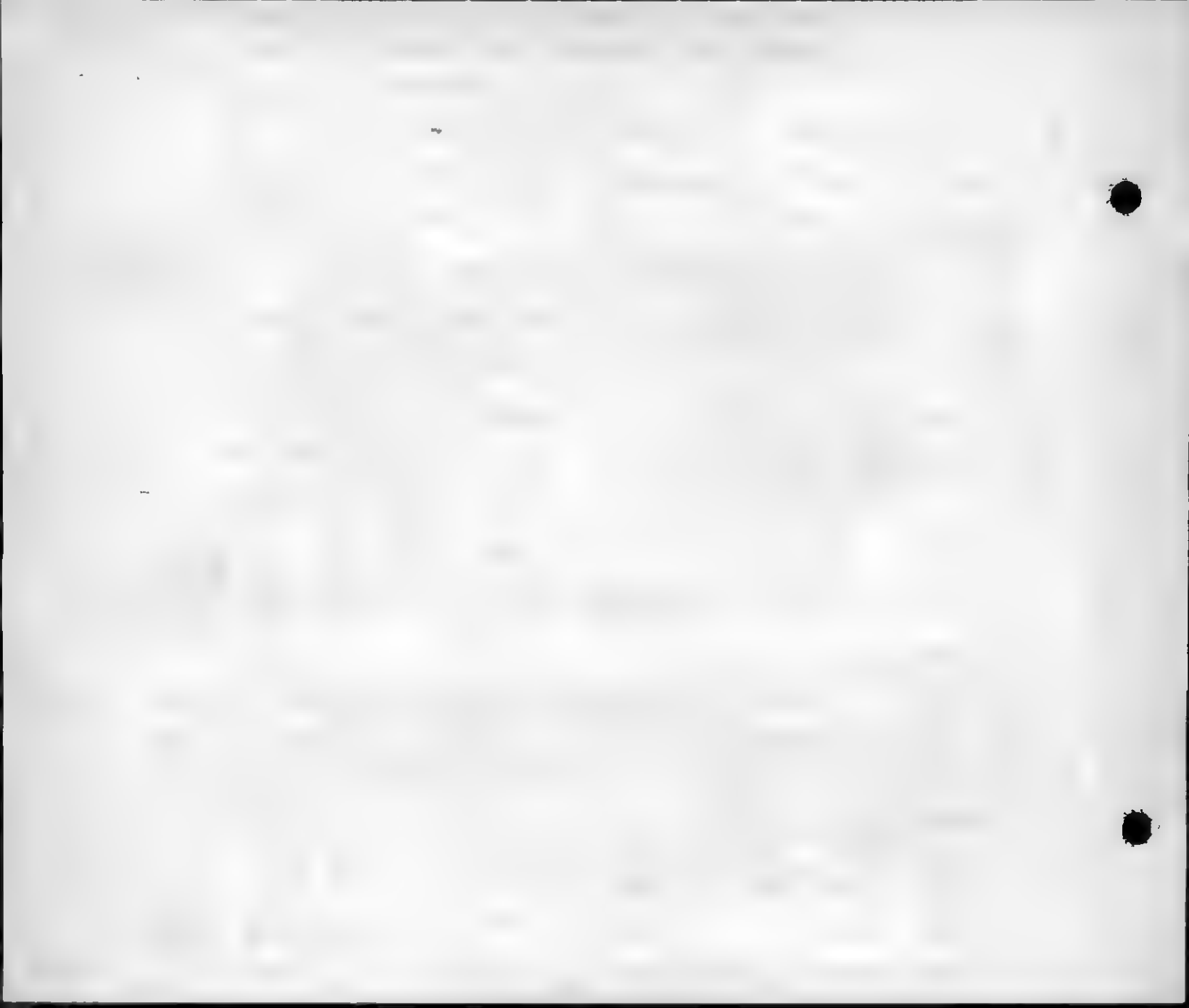
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DEL</u> <u>COO</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DEL</u> <u>COO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEL</u>		c. LENGTH OF STAY IN 1b <u>4</u> <u>55</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEL</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DEL</u> <u>COO</u> <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>FRANKLIN</u> Last <u>LEE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/1908</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Gorman, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph E. Lee</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn E. Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Korean War</u>		16. SOCIAL SECURITY NO. <u>36-48-2901</u>		17. INFORMANT <u>Henry Lee</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>470X</u> IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA, BILATERAL</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, JR.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DEL</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Feaster, Jr.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 6254 1-8-60 et

13757

CERTIFICATE OF DEATH

13730

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller				c. LENGTH OF STAY IN TB 3Yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willow St.			
d. STREET ADDRESS Willow St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOMINIK Middle - Last LOMBARD				4. DATE OF DEATH Month DEC. Day 30 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1867	
9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 358-22-0912		17. INFORMANT Mrs. Nellie Pratt, Kitzmiller, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Duodenal Ulcer INTERVAL BETWEEN ONSET AND DEATH 5 yrs 7/							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 28, 1955 to Dec. 30, 1959 , that I last saw the deceased alive on Dec. 28, 1959 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph Calandrella M.D.				ADDRESS (Street, city or town, state) Kitzmiller, Md. DATE SIGNED Dec. 31-59			
PHYSICIAN'S NAME (Type) Dr. Ralph Calandrella, M.D. Kitzmiller, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1960		22c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, Mineral Co. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JAN 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13731

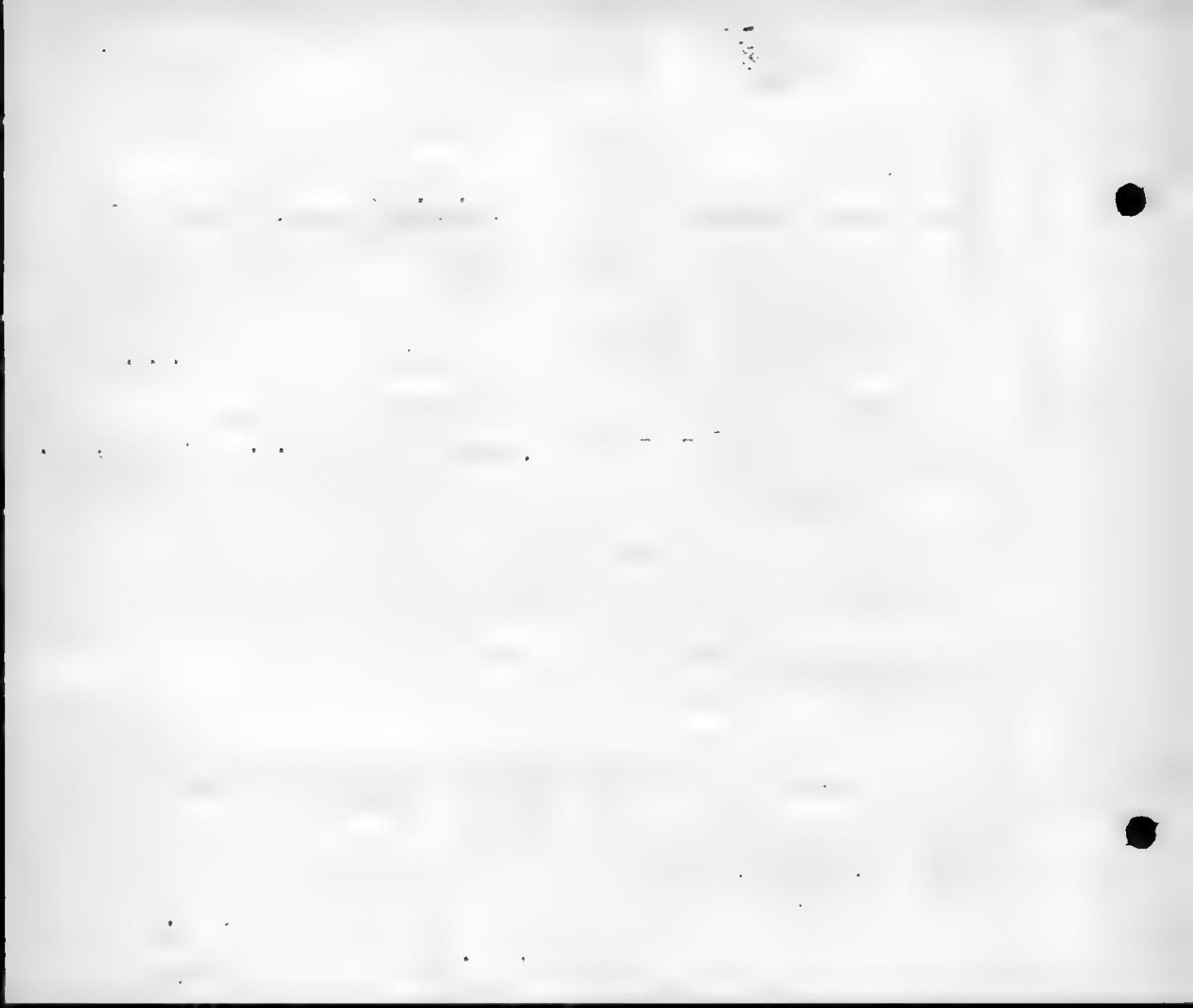
Reg. Dist. No.

13758

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Garrett Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Maryland				c. LENGTH OF STAY IN 1b 55 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Stanley Last Lucas				4. DATE OF DEATH Month Dec Day 24 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/79	9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME not Known				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO 215-36-9806			
17. INFORMANT Mrs. Vicki Lucas Kley				Address R.D. 2 Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Heart Disease DUE TO Arteriosclerosis (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 months 2 years 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Mar 26 , 19 55 , to 12/24 , 19 59 , that I last saw the deceased alive on December 24 , 19 59 , and that death occurred at 10:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland, Md.			
DATE SIGNED 24 Dec 59							
PHYSICIAN'S NAME (Type) Dr. Andrew E. Mance				Oakland, Maryland			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial				22b. DATE THEREOF 12/26/1959		22c. NAME OF CEMETERY OR CREMATORY Oakland Catholic Cemetery Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kray				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

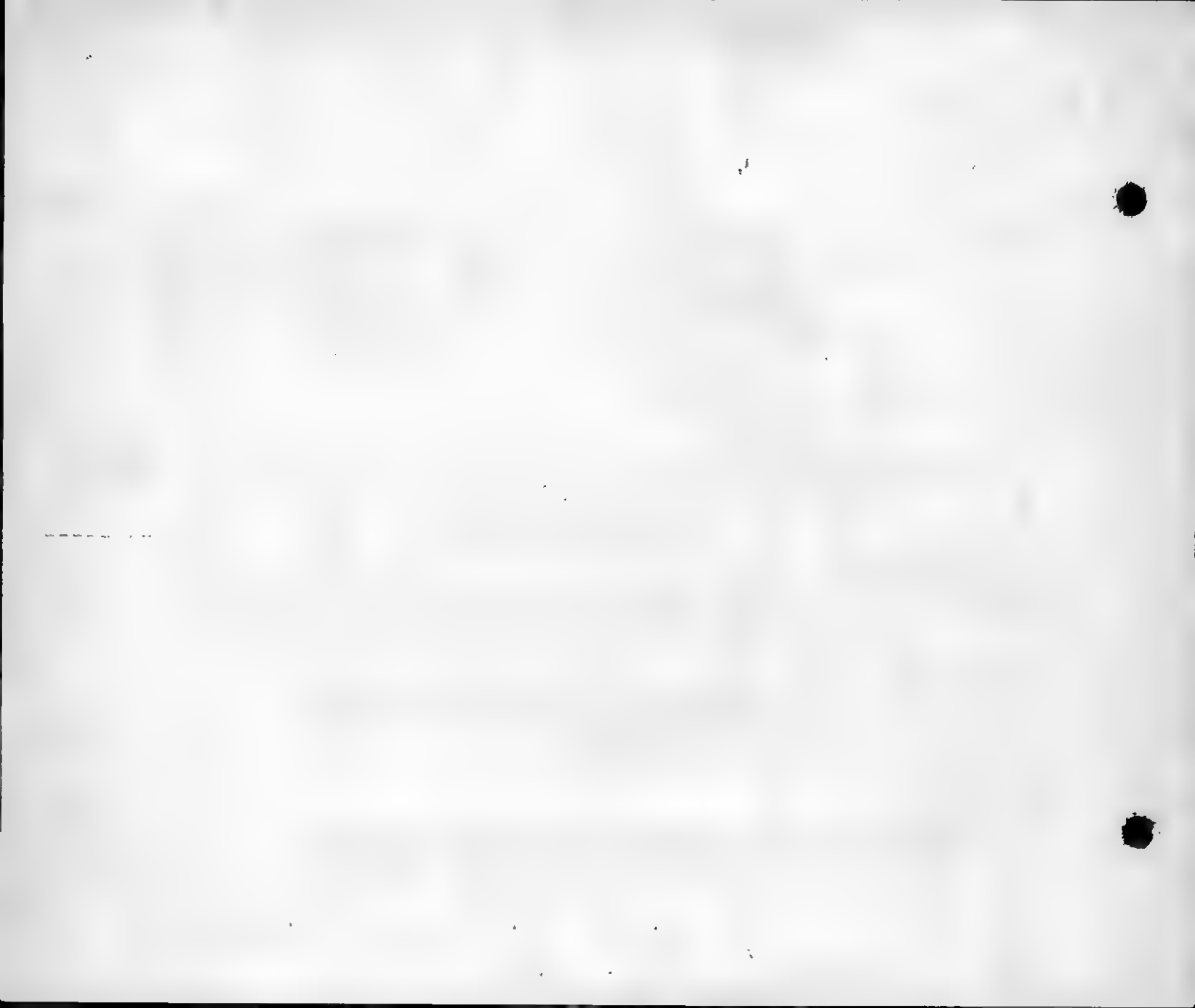
13 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18732

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MONTGOMERY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FROSTBURG MD		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE, MD		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 12415 CARROLL AVE.			
3. NAME OF DECEASED (Type or print) First VERNON Middle LESLIE Last MICHAELS				4. DATE OF DEATH Month DEC. Day 5 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 18 1923	9. AGE (in years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 5 Days 5	IF UNDER 24 HRS. Hours 5 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contemprl Asse.		10b. KIND OF BUSINESS OR INDUSTRY Cabinet Maker		11. BIRTHPLACE (State or foreign country) ivilton, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ERNEST Q MICHAEL				14. MOTHER'S MAIDEN NAME MAGGIE SARA LEWELLYN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 217-14-4277		17. INFORMANT Mrs. Mary Michael, 12415 CARROLL AVE		Address ROCKVILLE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) -----				INTERVAL BETWEEN DEATH AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/8/57		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Don Williams				ADDRESS Shantelle, Md.		24a. REC'D BY REGISTRAR DEC 16 '59	
				24b. REGISTRAR'S SIGNATURE James H. Feaster			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13760

CERTIFICATE OF DEATH

Reg. Dist. No.

13753

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mt. Lake Park</u>			
c. LENGTH OF STAY IN 1b <u>6 wks.</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leitha Ann</u> First <u>Meville</u> Middle Last				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1900</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Calif. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Binnix</u>				14. MOTHER'S MAIDEN NAME <u>Catherine (L. B. Binnix)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Kathryn Binnix</u> Address <u>Mt. Lake Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Myocardial Failure and</u> <u>272X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Pneumonitis</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>10 days</u> <u>8-10 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>26 April, 1959</u> , to <u>18 Dec., 1959</u> , that I last saw the deceased alive on <u>19 Dec., 1959</u> , and that death occurred at <u>Mt. Lake Park, Md.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>101 Third St., Oakland, Maryland</u> DATE SIGNED <u>22 Nov '59</u>							
ACTUAL SIGNATURE <u>Andrew E. Wance</u> M.D. <u>101 Third St., Oakland, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Andrew E. Wance</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/22, 1959</u>		<u>Oakland Cemetery</u>		<u>Oakland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Binnix Funeral Home</u>				ADDRESS <u>Baltimore, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hester</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

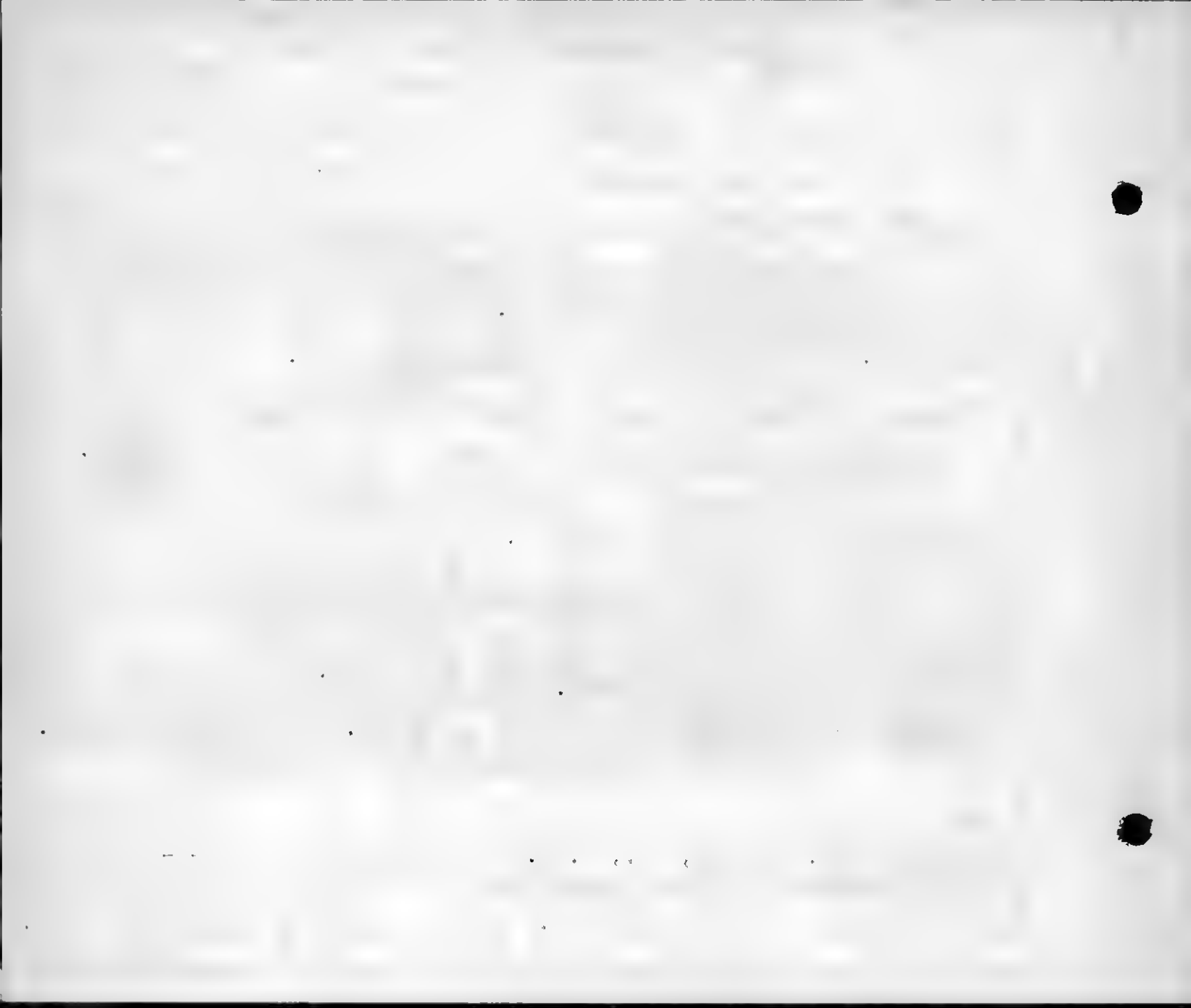
13761

Item 10, Min G-15 1/16/59.cac

Reg. Dist. No. 13734

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett</u>		c. LENGTH OF STAY IN 1b <u>Time</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Accident</u>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Harry</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7, 1938</u>
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cover for Denton, Ohio, bench assembly</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accident</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Clara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>320-34-1299</u>	
17. INFORMANT <u>Clara</u>		Address <u>Garrett, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured Heart</u> DUE TO <u>Crushed Chest, Left</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Sudden</u> DUE TO <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>In head on auto-truck collision. Deceased was driver of auto.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>In head on auto-truck collision. Deceased was driver of auto.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:15 a.m. 12-7-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(Nr) Accident Garrett Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		DATE SIGNED <u>12-7-59</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>12-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Garrett</u>	22d. LOCATION (City, town, or county) (State) <u>Garrett Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		24a. REC'D BY REGISTRAR <u>DEC 16 '59</u>	
ADDRESS <u>Garrett, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (10M)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

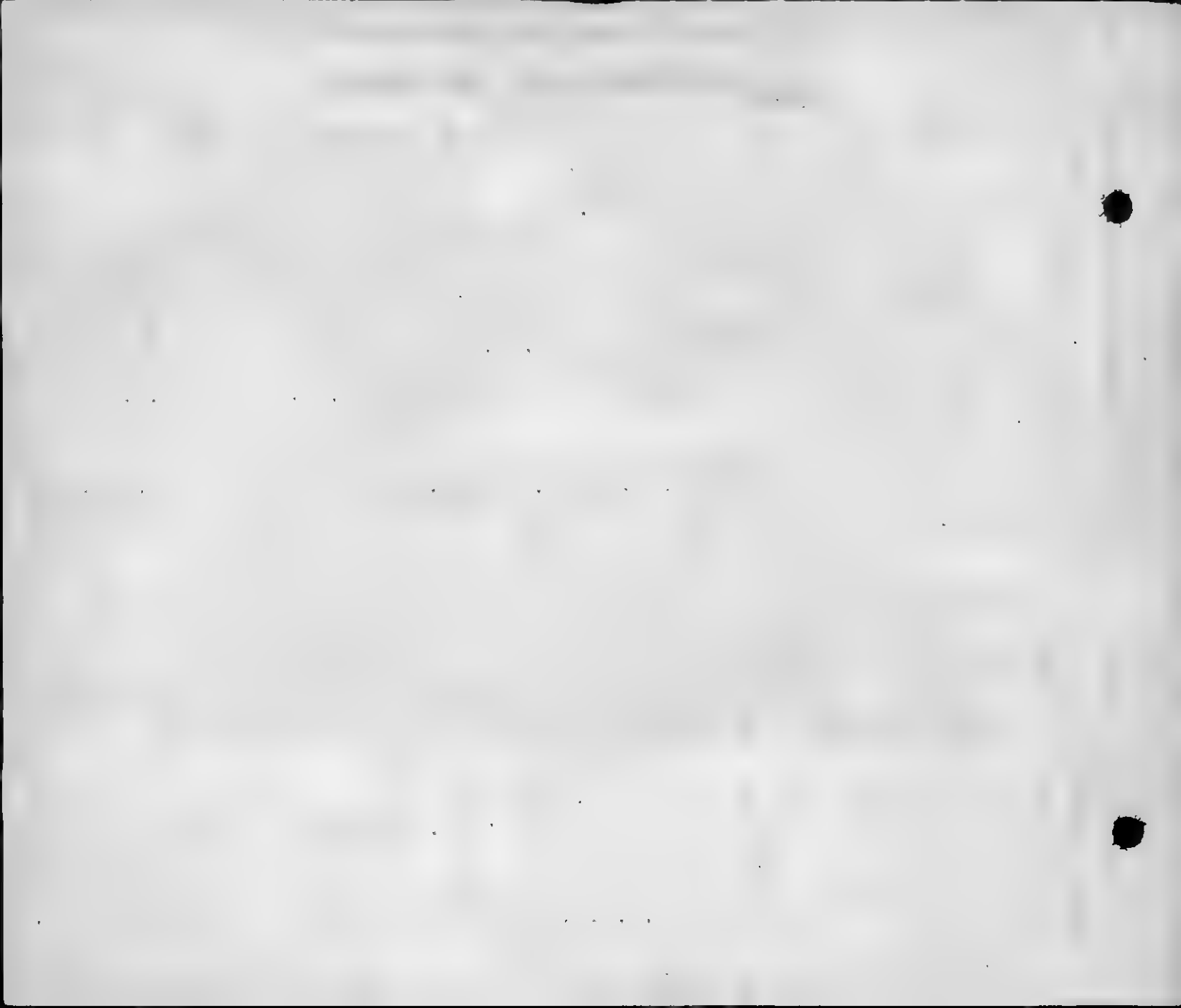
13762

CERTIFICATE OF DEATH

13735

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>				STATE <u>Maryland</u> COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Kitzmiller</u>		<u>4Yrs.</u>		TOWN <u>Kitzmiller</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Willow Street</u>				STREET ADDRESS (If rural give location) <u>Willow Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Flo</u> (Middle) <u>Inez</u> (Last) <u>Rawlings</u>				(Month) <u>Dec.</u> (Day) <u>7</u> (Year) <u>19 59</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, RE-MARRIED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Nov. 23, 1892</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Elk Garden, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Albert Warnick</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Simpson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>236-12-0089B</u>		17. INFORMANT & ADDRESS <u>Mrs. May Knox, Kitzmiller, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19 57</u>, to <u>Dec 7 19 59</u>, that I last saw the deceased alive on <u>Dec 7 19 59</u>, and that death occurred at <u>9:15 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Lupe Colomella</u>				DATE SIGNED <u>Dec 8-59</u>			
				ADDRESS (Street, city, town, state) <u>Kitzmiller Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/10/59</u>		<u>I.O.O.F. Cemetery</u>		<u>Elk Garden, Mineral Co. W.Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Arthur S. K...</u>		<u>H.C. Leighton - Capeland, Md.</u>			
DATE <u>DEC 14 '59</u>							



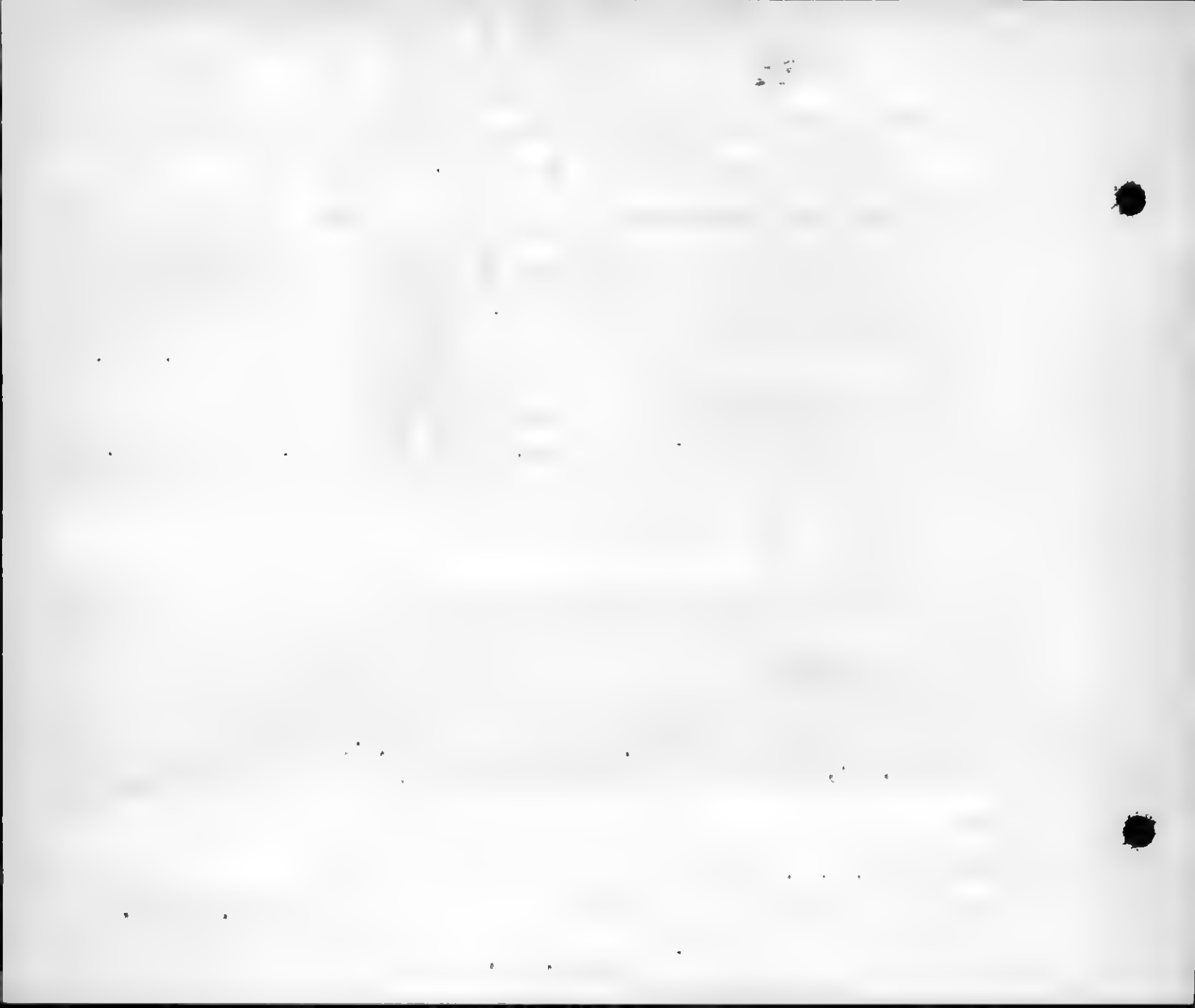
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13763 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

13736

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK			
				f. STREET ADDRESS "F" Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle REBECCA Last RIGGS				4. DATE OF DEATH Month DECEMBER Day 11 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883	9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) EVERETT, PA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME JOHN PATTERSON CALHOUN			
14. MOTHER'S MAIDEN NAME ANNIE GIBSON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. ---				17. INFORMANT DAUGHTER MRS. BONNIE CARLSON Address MT. LAKE PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Apr. 3, 1958 , 19____, to Dec. 11, 1959 , that I last saw the deceased alive on Dec. 11, 1959 , and that death occurred at 5:05 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. E. Mance				ADDRESS (Street, city or town, state) Oakland Md			
DATE SIGNED 12 Dec 59							
PHYSICIAN'S NAME (Type) DR. A. E. MANCE				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/1959		22c. NAME OF CEMETERY OR CREMATORY Rock Hill Cemetery		22d. LOCATION (City, town, or county) (State) near Everett, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. E. Reighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE DEC 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

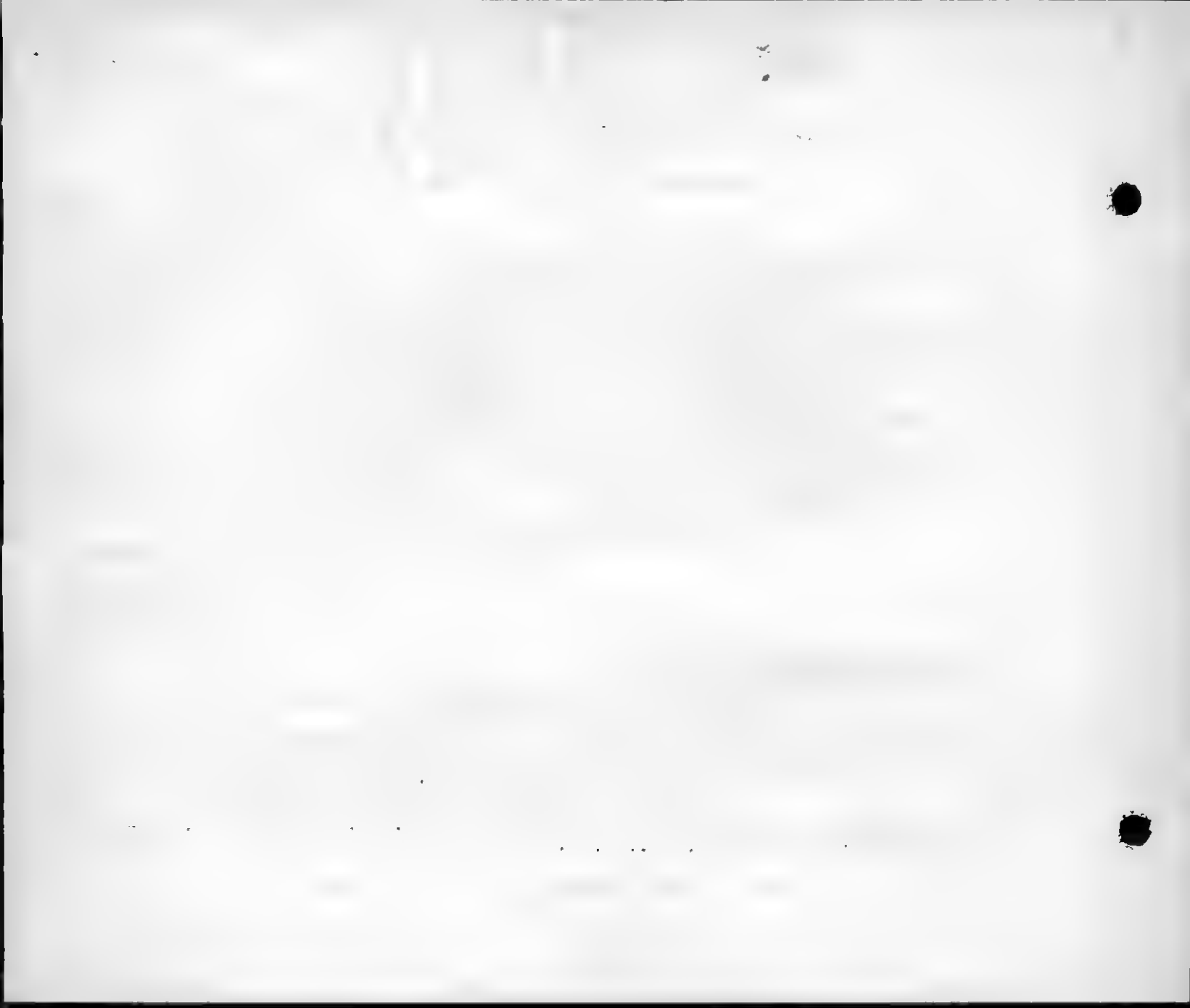
13764

CERTIFICATE OF DEATH

Reg. Dist. No.

13757

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE - b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett		c. LENGTH OF STAY IN 1b 11 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oakland	
		f. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) First John Middle Walter Last Schoen		4. DATE OF DEATH Month 12 Day 8 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1891
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Industry	
11. BIRTHPLACE (State or foreign country) West Virginia, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Min Schoen		14. MOTHER'S MAIDEN NAME Elizabeth Smale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 2-2-44-6712	
17. INFORMANT Mrs. Anna Schoen		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Starvation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach with metastases DUE TO (c) months			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 13, 1952 , to 12-1-59 , 19____, that I last saw the deceased alive on 12-1-59 , 19____, and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2nd. St., Oakland, Md. DATE SIGNED 12-10-59			
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.		PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/1959	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John L. Funeral Home		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE DEC 16 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13765

CERTIFICATE OF DEATH

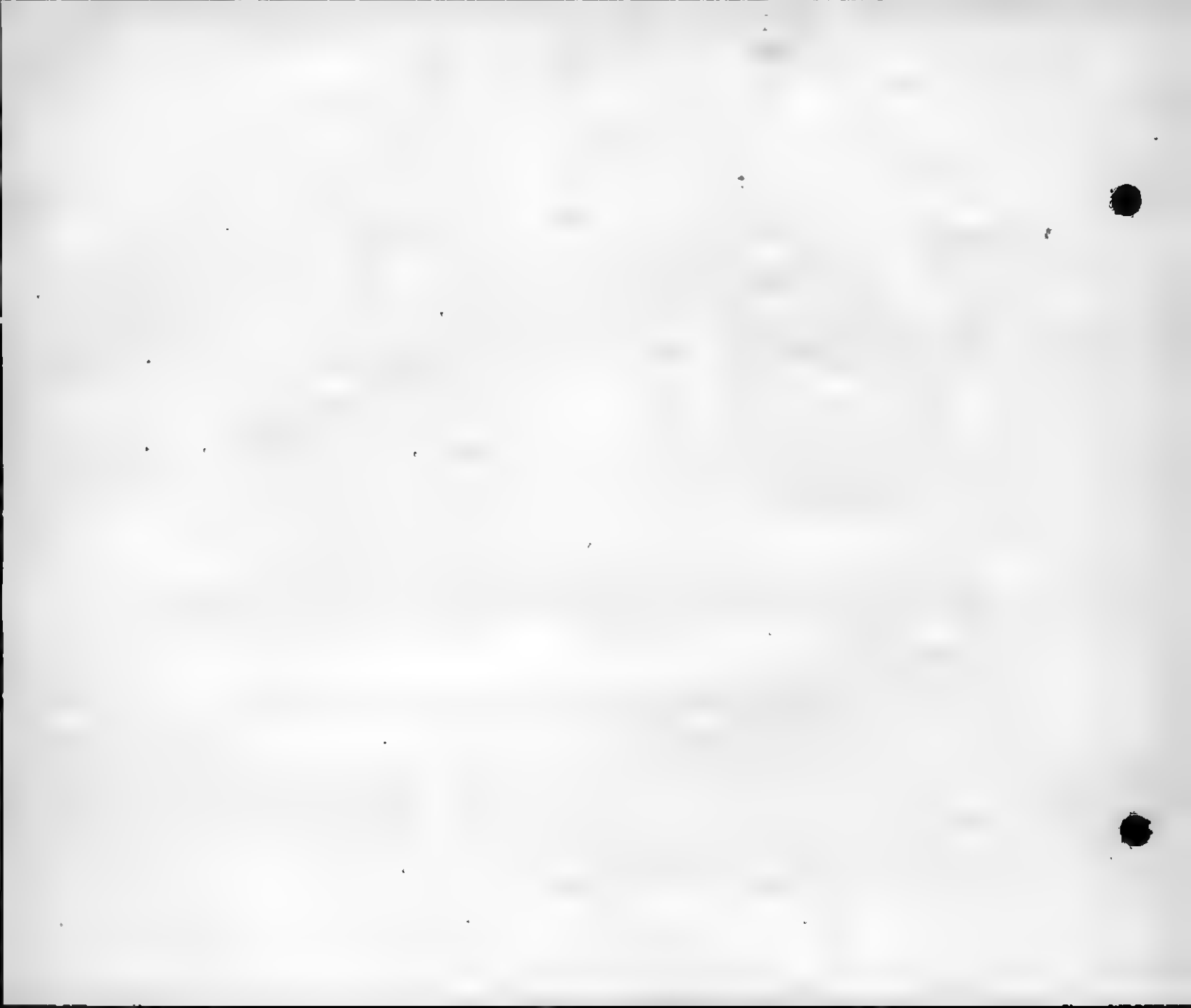
Reg. Dist. No.

13758

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mtountain Lake Park</u>			c. LENGTH OF STAY IN 1b <u>6 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X State Line</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weber Nursing Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Prinkey</u> Middle <u>Smith</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1959</u>		5. SEX <u>777</u>		6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1868</u>		9. AGE (In years last birthday) yrs <u>91</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>16</u> Hours <u>19</u> Min <u>59</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Henry Smith</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Freeland</u>				
15. WAS DECEASED EVER IN U. S. ARMY OR NAVY? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Jonas Smith,</u>		Address <u>Pittsburgh, Pa.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>23/X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>Years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Stroke 6 yrs ago</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <u>1-25, 1959</u> , to <u>12-16, 1959</u> , that I last saw the deceased alive on <u>12-16, 1959</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				ADDRESS (Street, city or town, state) <u>582-1st. Oakland and</u>				
PHYSICIAN'S NAME (Type) <u>JAMES H. FEASTER, JR. M.D.</u>				DATE SIGNED <u>12-16-59</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		22d. LOCATION (City, town, or county) <u>Addison Twp</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman - Grantsville, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 23 59</u>		24b. REGISTRAR'S SIGNATURE <u>John L. Hand</u>		
24c. REGISTRAR'S SIGNATURE		ADDRESS		24d. REGISTRAR'S SIGNATURE		ADDRESS		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13766

CERTIFICATE OF DEATH

Reg. Dist. No.

13730

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 14 hr.-25 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				/d. STREET ADDRESS MT. LAKE PARK			
3. NAME OF DECEASED (Type or print) First CHARLES Middle RAY Last TAYLOR				4. DATE OF DEATH Month DECEMBER Day 4 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 18, 1900	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR DEALER		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARCELLUS TAYLOR				14. MOTHER'S MAIDEN NAME ELIZABETH WHITEHAIR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-3513		17. INFORMANT CHARLES A. TAYLOR Address Mt. Lake Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO Myocardial heart disease & hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) & failure (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 Days 2 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-25 , 19 55 , to 12-3 , 19 59 , that I last saw the deceased alive on 4 Dec , 19 59 , and that death occurred at 12:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md		DATE SIGNED 4 Dec 59	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.				OAKLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/1959		22c. NAME OF CEMETERY OR CREMATORY Gortner Cemetery		22d. LOCATION (City, town, or county) (State) near Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Reighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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13767

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cuppitt Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Francis Louise Tusing</u>			4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1881</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baking</u>		11. BIRTHPLACE (State or foreign country) <u>Elk Garden, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Tusing</u>				14. MOTHER'S MAIDEN NAME <u>Silva Demit</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ralph E. Dawson Kingwood, W. Va.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Right Breast</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>w/ln metastases</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> , to <u>Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>12/15/59</u>							
ACTUAL SIGNATURE <u>E. G. Baumjarter</u> M.D.				PHYSICIAN'S NAME (Type) <u>E. Irving Baumjarter</u> <u>25 Alder St. Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>12/14/1959</u>		<u>Oakland Cemetery</u>		<u>Oakland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnien Funeral Home</u> ADDRESS <u>Oakland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

